Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMPREHENSIVE PAIN MANAGEMENT
5734 SPOHN DR STE A
CORPUS CHRISTI, TX 78414

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-1555-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary from Table of Disputed Services: "RATIONALE: Physician saw the patient for an office visit for his compensable injury. According to TWCC Fast Facts, if the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury. Original claim submitted on 06/15/10. First EOB denial received on 07/28/10. First request for reconsideration was sent on 07/29/10. Claim clearly submitted and appealled [sic] within a timely manner.

Amount in Dispute: $95.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided E&M services on 6/8/10 then billed Texas Mutual CPT code 99214 for this on or about 6/15/10. (Exhibit 1) Upon receipt of the bill, Texas Mutual reviewed the documentation, and concluded it did not substantiate code 99214. The requestor on or about 10/22/10 requested reconsideration of the denial. (Exhibit 2) DWC Rule 133.250 (a and d) states: '(a) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action…d) The requestor for reconsideration shall…(1) reference the original bill and include the same billing codes, date(s) of service, and dollar amount as the original bill…'…The bill is untimely. No payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2010	99213	$95.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §133.250 sets out the procedures for health care providers to request reconsideration for payment of medical bills.
4. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 14, 2010
   - CAC-B22- This payment is adjusted based on the diagnosis.
   - CAC-150-Payer deems the information submitted does not support this level of service.
   - CAC-16- Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code.)
   - 225- The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 890-Denied per AMA CPT code description for level of service and/or nature of presenting problems.
   - 907- Only treatment rendered for the compensable injury is reimbursable. No t all conditions indicated are related to the compensable injury.

   Explanation of benefits dated November 29, 2010
   - CAC-29- The time limit for filing has expired.
   - 731-Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05

   Explanation of benefits dated January 03, 2011
   - CAC-193-Originally payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-29- The time limit for filing has expired.
   - 731-Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
   - 891-No additional payment after reconsideration.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit a reconsideration in accordance with 28 Texas Administrative Code §133.250 and does the submitted documentation support that the disputed bill was submitted timely in accordance with Texas Labor Code §408.027, §408.0272 and Texas Administrative Codes §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute, for that reason, the health care provider and requestor in this dispute were required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. 28 Texas Administrative Code §133.250(d), "The request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amount as the original bill…" Review of the documentation submitted by the Requestor finds a bill with printed date 06/15/10 for CPT code 99214 with a billed amount of $180.00 and two bills with printed dates 07/29/10 and 10/22/10 for CPT code 99213 with a billed amount of $115.00. Because the Requestor changed the CPT code and the dollar amount on bill upon

reconsideration, the Division concludes that the Requestor submitted a "new" bill. No documentation was found to sufficiently support that the new bill was submitted within 95 days from the date services were provided.

3. In accordance with Texas Labor Code §408.027, the Requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the service in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 23, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.